Member Reimbursement Form for Medical Claims

KAISER PERMANENTE®

NOTE: Prescription Drugs with a date of service 1/1/16 and after need to go to OptumRx for processing. Please complete the OptumRx Claim form.

ONE FORM PER PATIENT PER PROVIDER

Please print clearly, complete all sections and sign. Retain copy for personal records.

Reset Form | Print

1. Patient's Name: (Last) (First) (Middle)	2. Patient's Member I.D. #	3. Patient's Date of Birth: _____ Patient's Sex: ☐ M ☐ F
4. Subscriber's Name: (Last) (First) (Middle)	5. Subscriber Member I.D. #	6. Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
7. Patient's Address:		8. Patient's type of insurance: ☐ HMO ☐ Options/Alliant ☐ PPO ☐ Medicare

9. **Custodial Parent Information:** For reimbursement requests from a Parent for a child (under the age of 18) when the requesting Parent meets both of the following requirements:
   1. Parent is not enrolled in the same Kaiser Permanente plan as the child
   2. Parent does not reside in the same household as the subscriber under the child's Kaiser Permanente plan

Legal Custodian's Name: _____ Legal Custodian's Contact Phone #: _____

Custodian Requesting Reimbursement Name: _____ Custodian Requesting Reimbursement Contact Phone #: _____

Address payment is to be mailed to: _____

If your child is covered under two or more health plans, state law determines the order of benefits for processing claims.

10. Practitioner Information:	11. Provider Information:	12. Condition was related to:
Attending Practitioner's Name: _____ Referring Practitioner's Name: _____	Provider's Name: _____ Provider's Tax I.D. #: _____ Provider's Billing Address: _____	A. Patient's Employment? L&I ☐ Yes ☐ No B. Auto Accident? ☐ Yes ☐ No C. Date of Incident: _____

13. The following information must be obtained from your provider, or must be included on your itemized statement from your provider. Do not send originals as they will not be returned to you.

Dates of Service	Place of Service (Office, ER, Urgent, Hospital, Clinic, Pharmacy, Ambulance, Home)	Diagnosis Code (DX)	Procedure Codes	Units/ Days	Amount Paid

14. Foreign Claims:

For services out of country, please provide name of country: _____

Where services were rendered: ☐ Office/ Clinic ☐ ER ☐ Urgent Care ☐ Hospital ☐ Pharmacy

Please explain injury or illness:

Itemized bills, receipts, and statements must be translated prior to submittal. Translation will be at the members expense. All Inpatient claims must be submitted with translated chart notes.

15. I have attached one of the following proof of payments:

- ☐ The front and back of the cleared check written to the provider, or bank encoded copy of the front check written to the provider.
- ☐ A copy of a credit card statement that includes the charges and the provider's name.
- ☐ A copy of the receipt, with the provider's name and address preprinted on the receipt.

Note: Itemized statements/ invoices do not count as proof of payment.

16. Information about payment(s) made:

Was there a discount for the services?
☐ Yes ☐ No

If Yes, is the amount paid after the discount?
☐ Yes ☐ No

Is there a balance due?
☐ Yes ☐ No

Note: if there is a balance due to the provider you may not be entitled to a refund.

17. Other Insurance information:

Is the patient covered by another health plan? ☐ Yes ☐ No

Subscriber name for other insurance:

_____

Name of other insurance company:

_____

Did other insurance make a payment?
☐ Yes ☐ No

If yes, include Explanation of Benefits from other insurance plan(s).

18. Signature is required:

I attest that the above information is true and accurate, and the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be cancelled and I may be subject to criminal and / or civil penalties for false health care claims.

Signature: _____ **Date:** _____

For any questions please contact Member Services toll-free at 1-888-901-4636, (TTY Relay: 711 or 1-800-833-6388).
Or visit kp.org/wa, click on "Member Services" and send an email.

Reimbursement requests will be processed within 60 days of receipt.
Itemized receipts, invoices, and **proof of payment** must be submitted, otherwise form may be sent back for lack of information.

Submit all documents to:

Claims Processing
Kaiser Permanente
P.O. Box 34585
Seattle, WA 98124-1585

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Please complete all items on the claim form. If the information requested does not apply to the patient, indicate N/A (Not Applicable). Special care should be taken when completing the following sections:

10. **Practitioner Information** – Please fill out attending practitioner's name with the physician that was seen for services. Please fill referring practitioner's name with the physician that referred you if applicable.
11. **Provider Information** – Please fill out provider name with the name of the facility that was visited. Please fill out Provider Tax ID with the facility's Tax ID (this number will need to be obtained from the provider). Please fill out provider billing address with the facility's address.
12. **Condition was related to** – Please indicate if the injury or reason of visit was related to your employment (L&I), or an auto accident, and if yes to either of them please indicate the date of accident.
13. **Itemization** – This information must be obtained from your provider, or must be included on your itemized statement from your provider. If this information is included on your itemized statement you can state please review attached itemized statement.
14. **Foreign Claims** – Please complete this section if your services were completed outside of the country, otherwise indicate N/A.
15. **Proof of payment** – Please indicate what type of proof of payment you have attached with this form.
16. **Payment information** – Please answer each question by checking the box that applies to the payment(s) you made to the provider.
17. **Other insurance** – Please indicate whether you have coverage from another insurance, if applicable the name of the subscriber for the other insurance and the name of the other insurance, and indicate by checking the box if they made a payment.
18. **Signature** – This form must be signed and dated by either the subscriber or the patient.

Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Kaiser Permanente:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact the Kaiser Permanente Civil Rights Coordinator.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Kaiser Permanente Civil Rights Coordinator, Kaiser Foundation Health Plan of Washington Headquarters, 320 Westlake Ave. N., Suite 100, GHQ-E2N, Seattle, WA 98109, 206-448-5819, 206-877-0645 (Fax), complianceoffice@kp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Kaiser Permanente Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(Chinese)**：注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-901-4636 (TTY：1-800-833-6388 / 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY：1-800-833-6388 / 711）.

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

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Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ (Khmer)**៖ ប្រយ័ត្ន៖** បើសិនអ្នកនិយាយខែរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់បំរេអក។ ចូរទូ រស័ព1-888-901-4636 (TTY: 1-800-833-6388 / 711។

日本語(Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-901-4636（TTY:1-800-833-6388 / 711）まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 (رقم هاتف الصم والبكم: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS : 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.